REMARKS OF

THE HONORABLE

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CHAIRMAN,

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BEFORE

THE AMERICAN GROUP PRACTICE ASSOCIATION

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GOOD AFTERNOON,

I'M PLEASED TO BE ABLE TO JOIN YOU TODAY FOR YOUR CONGRESSIONAL FORUM. YOUR MEETING IS ESPECIALLY TIMELY: THE BUDGET RESOLUTION FOR THE HOUSE WAS COMPLETED YESTERDAY, RE-AUTHORIZATIONS FOR EXPIRING AUTHORITIES SHOULD BE COMPLETED BY THE FIFTEENTH, AND THE COMMERCE COMMITTEE WILL BEGIN ITS BUDGET RECONCILIATION PROCEEDINGS VERY SOON.

AS YOU CAN SEE BY THIS SCHEDULE - AND AS I'M SURE YOU ALREADY KNEW - THIS IS A VERY BUSY CONGRESS.

BUT IT IS A CONGRESS AND ADMINISTRATION OF NUMBERS.

THE ARGUMENTS ON CAPITOL HILL AND IN THE WHITE HOUSE ARE ONLY ABOUT BUDGETS AND NOT ABOUT PROGRAMS.

AND IT IS, I THINK, REVEALING THAT THE REAGAN BUDGET CUTS WERE AVAILABLE IN FEBRUARY, BUT THAT ITS PROPOSED BLOCK GRANT LEGISLATION WAS NOT INTRODUCED UNTIL APRIL 10, AND THAT THERE IS STILL NOT ONE BIT OF SERIOUS PROGRAM ANALYSIS OR SUPPORTING DATA FOR THE ENORMOUS CHANGES THAT THEY SUGGEST.

LET ME PUT IT ANOTHER WAY. THE FIRST DIPLOMATIC VISITOR TO CALL ON MR. REAGAN AFTER HE BECAME PRESIDENT WAS THE PRIME MINISTER OF JAMAICA, WHO TOLD AT THAT TIME

WHAT HE DESCRIBED AS A JAMAICAN FOLK TALE. IT WENT SOMETHING LIKE THIS.

THERE WAS ONCE A CENTIPEDE WHO WAS IN GREAT PAIN FROM ARTHRITIS AND FOUND MOVING VERY DIFFICULT. HE WENT TO HIS DOCTOR - A STORK - TO ASK FOR ADVICE AND HELP. THE STORK LISTENED SYMPATHETICALLY TO THE CENTIPEDE'S SAD STORY AND THEN LOOKED AT THE CENTIPEDE AND LOOKED AT HIMSELF.

AFTER THINKING FOR A MOMENT, THE STORK SUGGESTED, "YOU SHOULD CUT OFF ALL BUT TWO OF YOUR LEGS. THEN YOU WON'T BE IN SUCH PAIN."

THE CENTIPEDE CONSIDERED THIS AND AGREED THAT THIS WOULD INDEED GET RID OF 98% OF HIS PROBLEM IMMEDIATELY. BUT THEN, WITH THE CAUTION OF ALL THOSE CREATURES THAT ARE SMALL AND MOVE SLOWLY, HE SAID, "I'LL FEEL BETTER, I'M SURE, BUT HOW WILL I MOVE?"

THE STORK SMILED AND SAID, "I'VE GIVEN YOU THE POLICY. WHAT YOU HAVE NOW IS A PROBLEM OF IMPLEMENTATION."

THE CONGRESS IS FILLED WITH THIS SORT OF POLICY THESE DAYS. AND THE REAGAN PROPOSALS FOR HEALTH ARE, UNFORTUNATELY, AMONG THEM.

LET ME GIVE YOU AN EXAMPLE OF WHAT THIS MEANS.

LAST YEAR THE FEDERAL GOVERNMENT PROVIDED LOANS OR SCHOLARSHIPS TO MORE THAN 25,000 NURSING STUDENTS. NEXT YEAR, THE ADMINISTRATION PROPOSES THAT WE CANCEL ALL

THESE AWARDS AND AID NONE.

LAST YEAR THE FEDERAL GOVERNMENT PROVIDED MONEY TO IMMUNIZE CHILDREN AGAINST POLIO, TETANUS, WHOOPING COUGH AND OTHER INFECTIOUS DISEASES. NEXT YEAR THE ADMINISTRATION PROPOSES TO IMMUNIZE 400,000 FEWER CHILDREN.

LAST YEAR 2.4 MILLION PERSONS RECEIVED CARE IN A COMMUNITY MENTAL HEALTH CENTER. NEXT YEAR THE ADMINISTRATION PROPOSES TO REPEAL THAT ENTIRE PROGRAM.

LAST YEAR WAS A THOUGHTFUL AND PRODUCTIVE TIME FOR ALL OF US AS WE DEBATED ISSUES OF MEDICAL EDUCATION, RESEARCH AND SERVICES.

THIS YEAR, I'M AFRAID, IS MUCH DIFFERENT.

THE ADMINISTRATION HAS BEEN NEITHER THOUGHTFUL NOR PRODUCTIVE ON THE SUBJECT OF HEALTH PROGRAMS. WITHOUT ANALYSIS, REPORTS, OR HEARINGS THE ADMINISTRATION NOW PROPOSES TO REPEAL SOME OF OUR MOST COST-EFFECTIVE PROGRAMS OF PREVENTION AND TREATMENT AND TO INSTALL A MEDICAID CAP WHICH IS NOTHING MORE THAN A SHIFTING OF COSTS FROM THE FEDERAL TREASURY TO HOSPITALS, PROVIDERS, AND THOSE STATE AND LOCAL GOVERNMENTS WHO CAN AND WILL HELP.

IT IS THE ADMINISTRATION'S ARGUMENT THAT SUCH REPEALS AND COST SHIFTING WERE PART OF THE ELECTION RESULTS. SUCH AN ARGUMENT IS EXAGERRATED AND HISTORICALLY BLIND.

THE EXPECTATIONS OF AMERICANS ARE FOR RESTRAINT IN COSTS, PERHAPS, BUT NOT RETREAT FROM SUCCESSFUL HEALTH CARE PROGRAMS. AND IT IS SUCH A RETREAT AND EVENTUAL DEPARTURE THAT MR. STOCKMAN AND MR. REAGAN ARE ADVOCATING.

LET ME REVIEW A FEW OF THESE PROPOSALS FOR YOU AND SUGGEST THEIR IMPACT.

FIRST, FEDERAL COSTS WOULD BE REDUCED BY LIMITING EXPENDITURES ON CARE FOR THE POOR. THE FEDERAL COMMITMENT TO SHARE WITH THE STATES IN THE COST OF CARE FOR THE INDIGENT UNDER MEDICAID - A 15 YEAR PARTNERSHIP - WOULD BE REPLACED BY A CEILING ON FEDERAL FINANCIAL INVOLVEMENT. THE STATES WOULD BE LEFT WITH THE IMPOSSIBLE TASK OF MEETING ANY NEEDS THAT EXCEED THE FEDERAL CONTRIBUTION OR REDUCING VITAL HEALTH AND LONG TERM CARE SERVICES.

THIS CUT - DESPITE ALL THE TALK ABOUT A "SAFETY NET" - IS TARGETED ON THE VERY POOREST OF OUR PEOPLE.

ANOTHER PROPOSAL TO REPLACE MANY EXISTING CATEGORICAL HEALTH PROGRAMS WITH BLOCK GRANTS TO THE STATES WOULD ALSO REDUCE FEDERAL COSTS AT THE EXPENSE OF THE POOR AND UNDERSERVED. FUNDING FOR A WIDE RANGE OF HEALTH, MENTAL HEALTH, AND PREVENTION ACTIVITIES WOULD BE REDUCED BY 25% AND THE STATES GIVEN TOTAL DISCRETION TO DECIDE HOW OR WHETHER TO CONTINUE ANY OF THESE PROGRAMS. BLOCK GRANTS

WOULD SLASH DOZENS OF ESSENTIAL HEALTH SERVICES INCLUDING PRENATAL CARE, IMMUNIZATIONS, FAMILY PLANNING, AND DRUG ABUSE COUNSELING.

THE REAGAN BUDGET ALSO PROPOSES TO ABOLISH TWO EXISTING FEDERAL PROGRAMS DESIGNED TO LIMIT HEALTH CARE COSTS - HEALTH PLANNING AND PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS. WHILE THESE PROGRAMS ARE NOT PERFECT, THEY ARE OUR ONLY TOOLS TO CONTROL COSTS. THE REAGAN BUDGET WOULD ABOLISH THESE PROGRAMS, AND REPLACE THEM WITH A HEAVY DOSE OF RHETORIC ABOUT A COMPETITIVE HEALTH CARE SYSTEM. BEYOND RHETORIC, HOWEVER, THE ADMINISTRATION HAS PROVIDED NO CONCRETE DETAILS ON HOW IT PLANS TO URGE DOCTORS AND HOSPITALS TO CHANGE THEIR CURRENT MODE OF OPERATION.

AND WHATEVER THE LONG-RANGE BENEFITS OF INCREASED COMPETITION, IT CLEARLY WON'T LIMIT COSTS IN 1982 OR 1983. EXPERIENCE FROM BOSTON, CLEVELAND AND DENVER INDICATES THAT YEARS ARE NECESSARY TO ESTABLISH SUCCESSFUL HEALTH CARE PLANS. EVEN THE STRONGEST ADVOCATES ADMIT THAT IT WILL TAKE COMPETITIVE REFORMS 10 YEARS TO CONTROL HEALTH CARE COSTS. YET THE REAGAN ADMINISTRATION ASKS US TO BELIEVE THAT 12 BILLION IN SAVINGS WILL ACCRUE TO MEDICARE OVER THE NEXT FIVE YEARS FROM THIS UNDEFINED PROPOSAL.

THE OVERALL EFFECT OF THE REAGAN POLICIES ARE SIMPLE TO PREDICT. IF THESE POLICIES ARE ADOPTED, THE NATION

AS A WHOLE WILL EXPERIENCE HIGHER HEALTH CARE COSTS, AND HEALTH SERVICES FOR MILLIONS OF OUR CITIZENS WILL BE REDUCED RATHER THAN IMPROVED.

WITHOUT ANY EFFORT TO RESTRAIN COSTS, FEDERAL, STATE, AND LOCAL GOVERNMENTS WILL ALL FACE EVER INCREASING EXPENSES FOR EXISTING BENEFITS AND EXISTING BENEFICIARIES. PRIVATE INDUSTRY WILL SEE BILLIONS OF DOLLARS OTHERWISE AVAILABLE FOR PLANT MODERNIZATION, ENVIRONMENTAL IMPROVEMENT AND BETTER WAGES AND BENEFITS DEVOTED TO HIGHER AND HIGHER HEALTH INSURANCE PREMIUMS.

BUT MOST IMPORTANTLY, CONTINUING INCREASES IN COSTS FOR OUR EXISTING PROGRAMS WILL INHIBIT - IF NOT PRECLUDE - EFFORTS TO IMPROVE SERVICES FOR ALL PEOPLE. FURTHER EFFORTS TO IMPROVE EFFECTIVE PREVENTIVE CARE FOR MOTHERS AND CHILDREN WILL BE DEFERRED. MEDICARE BENEFITS, WHICH ALREADY PAY LESS THAN ONE-HALF OF THE HEALTH CARE COSTS OF THE ELDERLY, WILL CONTINUE TO ERODE YEAR BY YEAR. THE MORE THAN 20 MILLION AMERICANS NOW WITHOUT ADEQUATE HEALTH INSURANCE AND THE 15 TO 25 MILLION OF OUR PEOPLE WHO LIVE IN RURAL AND INNER-CITY UNDERSERVED AREAS WILL SEE FEWER DOCTORS AND HOSPITALS AVAILABLE TO SERVE THEM.

HIGHER COSTS AND REDUCED CARE -- THAT IS THE MESSAGE OF THE REAGAN HEALTH BUDGET.

NOW LET ME ADD ALSO ADD SOME COMMENTS ABOUT THE PROCESS BY WHICH THE ADMINISTRATION IS ARRIVING AT THESE RESULTS.

IT IS A BAD PROCESS. IT IS NOT A REASONABLE WAY TO DEVELOP POLICY AND MAKE LAWS.

IN THE HOUSE AND THE SENATE THERE ARE AUTHORIZING, APPROPRIATING, AND BUDGETING COMMITTIES. IN THE HOUSE, THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT, WHICH I CHAIR, HAS JURISDICTION OVER ALMOST ALL FEDERAL HEALTH MATTERS, RANGING FROM MEDICAID TO THE NATIONAL INSTITUTES OF HEALTH TO THE HEALTH MAINTENANCE ORGANIZATION PROGRAM. THE HOUSE WAYS AND MEANS COMMITTEE ALSO HAS SOME JURISDICTION OVER MEDICARE BECAUSE OF ITS CONTROL OF TAXATION AND THE SOCIAL SECURITY TRUST FUND, BUT ITS ROLE IS LIMITED TO THESE SPECIALLY FUNDED PROGRAMS.

ON THE SENATE SIDE, THINGS ARE DIVIDED UP A BIT DIFFERENTLY AND THERE ARE TWO COMMITTEES THAT DEAL WITH HEALTH: THE FINANCE COMMITTEE, WHICH CONTROLS REIMBURSEMENT LEGISLATION, AND THE COMMITTEE ON LABOR AND HUMAN RESOURCES, WHICH CONTROLS THE GRANT PROGRAMS FOR HEALTH.

THESE AUTHORIZING COMMITTEES DESIGN FEDERAL PROGRAMS AND SET THE MAXIMUM MONEY WHICH <u>CAN</u> BE SPENT ON EACH.

EACH HOUSE ALSO HAS AN APPROPRIATIONS COMMITTEE WHICH DECIDES HOW MUCH MONEY <u>WILL</u> BE SPENT ON EACH PROGRAM.

AND, EACH HOUSE HAS A BUDGET COMMITTEE WHICH DECIDES HOW MUCH MONEY THE CONGRESS WILL SPEND OVERALL.

BUT THIS PROCESS IS NOW BEING TURNED ON ITS HEAD.

IN THEORY, THE AUTHORIZING COMMITTEES ARE TO DEVELOP LEGISLATION WITH A FULL UNDERSTANDING OF ITS SUBSTANCE AND IMPACT. THE COMMITTEES DEVELOP EXPERTISE IN SUBJECT AREAS AND ARE TO ADVISE THE HOUSE ACCORDINGLY.

BUT THAT IS NOT THE WAY THE PROCESS WORKS ANY LONGER. NOW A BUDGET RESOLUTION ESTABLISHES "POLICY" IN TERMS OF ABSTRACT DOLLAR "SAVINGS" AND LEAVES THE IMPLEMENTATION TO OTHERS--TO THE AGENCIES, TO THE STATES, TO THE POOR.

I WILL CONTINUE TO WORK FOR THE CONTINUATION AND REAUTHORIZATION OF THE FOURTEEN HEALTH PROGRAMS WITHIN MY SUBCOMMITTEE'S JURISDICTION. I HAVE INTRODUCED SEVERAL BILLS, MARKUPS ON THESE BILLS WILL TAKE PLACE IN THE VERY NEAR FUTURE, AND THE HMO BILL HAS ALREADY BEEN REPORTED TO THE FULL COMMERCE COMMITTEE.

BUT I AM CONCERNED ABOUT THE CONGRESS AND ADMINISTRATION OF NUMBERS AND RETREATS. I URGE YOU AND YOUR COLLEAGUES TO CONTACT YOUR REPRESENTATIVES AND SENATORS TO REMIND THEM THAT THERE WAS ONCE AND THERE STILL IS A REASON WHY THE FEDERAL GOVERNMENT BECAME INVOLVED IN HEALTH CARE. REMIND THEM THAT THE HEALTH BUDGETS WITH WHICH THEY ARE

DEALING ARE MORE THAN NUMBERS AND STATISTICS; THEY ARE PRESCRIPTIONS WHICH SHOULD BE FILLED AND ILLNESSES WHICH CAN BE PREVENTED OR CURED.

THANK YOU. I WILL BE GLAD TO ANSWER ANY QUESTIONS YOU MAY HAVE.

I am delighted to be with you. I am honored to be the first speaker at the first meeting of this organization and to be able to share with you some of my expectations for your profession coming up in Washington. I want to tell you a little about myself, if I might, in addition to the very fine introduction by Dr. Kristensen. I was a member of the California State Assembly for six years and I have been in the House of Representatives for six years. In the Congress we deal with a whole range of issues, national and international. I have a great interest in issues within the whole scope of matters that we in Congress deal with, but I have a special interest in the health area. I feel that a Congressman who becomes involved in all sorts of issues has no impact on any specific one.

I started off in the California Assembly with an interest in health issues for a number of reasons, but primarily because the district I represented in Los Angeles has one of the oldest populations in the country. In fact, in terms of the age of the constituency, it is second oldest in the country. So I focused my attention in the health area and joined the Committee on Health in the Assembly and later became Chairman of that Health Committee. When I was elected to Congress in 1975 I specifically joined the Interstate and Foreign Commerce Committee. The Interstate and Foreign Commerce Committee sounds like it has interstate and foreign commerce jurisdiction. It was the first committee in Congress that was formed when Congress was organized in 1789, and it had at that time interstate and foreign commerce jurisdiction.

Over the years the committee jurisdictions have changed. Our committee in fact has no foreign commerce jurisdiction at all. We do deal with a number of domestic commerce concerns relating to energy issues, communication, the whole area of consumer protection and regulatory affairs, and health jurisdiction. Although health issues were a very small part of the jurisdiction of the committee ten or fifteen years ago, it is now a major one since the government has become so actively involved in health-related issues.

I specifically joined this committee because of the jurisdiction of the Subcommittee on Health which had been chaired by Congressman Paul Rogers. Many of you may have heard of Paul Rogers who was from Florida. He was chairman of that subcommittee and had a distinguished record of accomplishment over the years. When he retired at the beginning of the last Congress, there was a vacancy for the chairmanship. Even though the Congress has always had a strict seniority system, many of us newer members decided that the filling of vacancies for chairmanships ought not be based solely on seniority.

In the past the seniority system meant that only men who served for twenty or thirty years became chairmen, which did not always produce the most able chairmen. So when the chairmanship opened, I ran for it, challenging two senior members. I ran on the basis that I had the background in the health area and that I could do more with that chairmanship than my other two senior colleagues. I was successful in winning the chairmanship.

It has been an exciting two years since I have been chairman. I plan to be chairman again when we convene in January of this next year since the Democrats still have control of the House of Representatives. But we are going to see a very dramatic change when we come back in January following this last election.

I want to reflect with you about some changes we might expect to see in the health area in the near future. I should point out that we are still in session, although, when I left Washington last night, I expected today to have been the last day of this session. A lame duck session, or a post election session, is

composed of the same Congressmen as prior to the election. The new Congress does not take over until January. It is a very difficult time, since so many of my colleagues were defeated in this last election, but a holdover Congress is still voting on some very important issues. While we expect it to end this week, there is a possibility it will go on longer with unpredictable results.

We are going to have a whole new crew of people running the government this January. There will be a new administration consisting of many who are not so new to those of us from California. When I was in the Legislature, Ronald Reagan was the Governor of the state and some of the people who I expect will be in his administration in the health area may well have also been in his administration here. We do not know who will be handling the Department of Health and Human Services and other appointed levels of the government that will be making policy decisions. Even with a new Republican Administration and Senate, though, I believe the problems we will be facing in health care will not be partisan ones.

We will be confronting difficult and complicated problems which will require of us as good a judgment as we can possibly muster with as much information as we can possibly get, to think through the consequences of what we are to do. One of the things that helped me when I was in Sacramento was to know that there were representative advocates of the various groups that had an interest in the health area. Mike Allen, whom I have known for many years from my days in Sacramento, is a person for whom I have a great deal of respect and who has always done an outstanding job of advocating the positions of the groups he represents. An advocate plays a very important part in the legislative process. We legislators are called upon to make decisions that affect all sorts of distinct, specific population groups, professional groups and business groups. We need to find out as much information as possible in making these decisions. I am pleased that you are now organizing to take a more active part with the Congress in preparing us for our job. If we change the law to move in one direction, we may adversely affect another group. We may not have even intended to have that consequence, but unless that group is represented and is part of that whole process, we may not be aware of those results. I strongly commend you for organizing with the purpose of looking to implementing policy and affecting the policy that comes out of Washington.

There are many people who would like to say the Federal Government ought not be involved in health care. The regulations that come out of HEW (now Health and Human Services) are complicated and burdensome ones. The regulations that come out of state and local governments mesh with the federal regulations, and for many of you who never intended to become lawyers, you are forced to try and figure out what it all means. You end up with a tremendous paperwork burden when all you want to do is practice medicine -- to provide care for your patients. But we are really at the point now where it is not realistic to talk about turning back the clock on the federal government's involvement in the health care area.

In 1965 we undertook the adoption of two major health care programs on the federal level. The Medicaid, Medicare, and California's Medi-Cal programs were adopted with the greatest compassionate motive --- to provide health care for our older people and for the poor on welfare. We wanted to provide health care or access to a health care system for these people. The Medicaid program was to be run in conjunction with the states, while the Medicare program was to be run nationally with the aid of fixed intermediaries. But what very few people realized in 1965 in adopting these programs was the cost that was going to result from these programs to government (state and federal) and to the private sector health insurance because of the inflationary impact on all health care costs. We also did not realize the kind of inflationary impact these programs were to have on the economy of our nation.

Inflation is still the number one domestic issue. It is the issue that President Carter was struggling with when he was trying to figure out some way to restrain cost in the health care area and recommended to us the hospital cost containment program. It will be the major issue that President-elect Reagan is going to have to deal with when he comes to power in Washington. If we are going to have an increase in the defense budget, which most of us now believe is necessary for us to have a credible force to deter any aggression anywhere in the world, it is going to cost us billions of dollars more than we are already spending.

If we are going to have a tax cut which a broad consensus now believes is necessary to spur domestic economic productivity, any hopes for a balanced budget will come about with cuts in domestic programs. The largest expenditure of money domestically has been in health programs: Medicare, Medicaid, and many others.

I want to briefly explain how these health care issues are dealt with structurally in Congress. I am Chairman of the Subcommittee on Health and the Environment, which is a subcommittee on the Interstate and Foreign Commerce Committee. We have the major jurisdiction in health, Food and Drug Administration issues, health manpower, the whole Medicaid program, and Medicare Part B. The House Ways and Means Committee, which at one time had jurisdiction over this whole health area but gave it up in a reform movement prior to my coming to Congress, has some residual jurisdiction in health because of its role in the taxing system. Its jurisdiction is restricted to the Medicare program because it has a special relationship to the trust fund for Social Security.

On the Senate side there are two committees that deal with health. There is the Subcommittee on Health and Scientific Research, which has been chaired by Senator Kennedy, and which is a subcommittee of the Labor and Human Services Committee. The major committee dealing with the health care expenditures for Medicare and Medicaid is in the Senate Finance Committee, which has been chaired up to now by Senator Russell Long. Next year the leading players in the Senate field of health will be changing. The Senate Finance Committee will no longer be chaired by Russell Long but by Robert Dole. What will happen to the Subcommittee on Health and Scientific Research is yet undetermined.

Each Congress lasts two years and has a corresponding number. This has been the ninety-sixth Congress. The ninety-sixth Congress failed to complete reauthorization for health manpower programs because we could not reach an agreement with the Senate on a bill. Although we had on the agenda for reauthorization the legislation for biomedical research at NIH, we failed to complete our work on that bill. These items will be added to the schedule of bills to be dealt with in the ninety-seventh Congress.

The Senate and the House had separate versions of Medicare-Medicaid package, which ended, because of a very unusual legislative procedure, in a conference on a bill for reconciliation under the Budget Act. Reconciliation sounds like something that belongs in family court, but in this case reconciliation means for each committee to meet the savings targets in the Budget Act. The reconciliation bill was a composite of all the savings proposals by the various committees put into one gigantic bill. What we did on the House side was take the Medicare-Medicaid bill that we had moving and put the total bill in the reconciliation package. The Senate did the same with their bill. Then we went to conference, a meeting of Senators and House members to work out differences in the versions of the bills passed by our respective houses. We concluded the conference report and on Wednesday we adopted it.

The conference report included sure changes in the Medicare-Medicaid system.

We did not go as far as either the Senate or the House had proposed, but there were a couple of areas I know are of special concern to you. The Senate proposed to save money by eliminating reimbursement for percentage arrangements by pathologists with hospitals. The House did not have a provision like that. When one house has a provision and the other does not, we can do a number of things. We can accept their position and then both houses would in effect adopt the same provision; we can come up with some compromise in between; or we can insist that the provision be dropped, which happened in this particular case. We insisted that the Senate proposal for elimination of the percentage contract be dropped. The House did not have language like the Senate's and it seemed to us that a section like that had to be thought through a little more carefully. I believe in the ability to have some flexibility for contractual arrangements between pathologists and hospitals depending on the local circumstances, and what emerged from the conference report in that area was to have no provision at all.

The second area, which is getting more and more legislative interest and is going to be a continuing issue for us in the next Congress, is how we deal with what has been called freedom of choice under the Medicare-Medicaid system, particularly Medicaid. Freedom of choice for the patient who is eligible under the program allows a patient to go to any provider for services and for that provider to be reimbursed. Many states are saying to us, we are the biggest purchasers of health care services because of all these people on Medicaid. Give us the power at the state government level as purchasers of these services to negotiate between all the providers and to contract with one or more providers at the lowest cost to us. In California the Brown administration has been proposing over the last couple of years to eliminate this freedom of choice in favor of competitive bidding for contracts to provide Medicaid health care services. That argument to me just does not hold up. If you eliminate the ability for the patient to choose the provider and have that person go instead to one under contract with the state, I believe that rather than encourage competition, you are going to eliminate it. We would end up with a monopoly for those who would deal with the state at the lowest possible cost, and I would expect at a relatively low quality of care for the patients involved. It would change the basic assumption of the program to allow patients to go into the mainstream of medicine. It would also provide a lever for states to squeeze and squeeze and squeeze so they could save money, but they certainly wouldn't be doing any favors for people who need health care services by narrowing the range of providers that would be eligible to participate in the program. I strongly resisted any change in this area, particularly the Senate proposal by Senator Talmadge. Senator Talmadge, by the way, was also the proponent of eliminating the percentage arrangement. We discussed possibly a pilot project to see how competitive bidding by states would work in certain specific areas, but we din not want to turn over the whole program and make such a dramatic change in what was basically a bill to try to meet the budget act savings. We rejected the elimination of freedom of choice which would have dramatically affected, I believe, you and others who practice medicine throughout the country and participate in these programs.

We did adopt a number of other items in the bill that will affect you and I am sure you will be going over them. Most of them have relatively minor impact. We did have a provision on the amount of mark-ups on clinical lab services under Medicare charged by the physician that in fact were done by an outside lab. We had a provision on preadmission diagnostic testing under Medicare. The conference agreement adopted the House version with an amendment to cover tests performed in physicians' offices. In effect, we said that we would later be hospitalized if it was done seven days prior to admission. We currently have a lot of built in incentives in the health care area which make providers do what we do not want them to do, and we have a lot of incentives for putting people in hospitals when there is no need for them to be hospitalized. In other words, we are providing services

to persons as inpatients when they can be served on an outpatient basis.

These basic issues that confront us in the health care area are going to be confronting us under the Reagan administration as they have under the Carter administration. How do you deal with a health care system that is costing more and more and more money? There are many interesting ideas being circulated that really cross philosophical lines. There are ideas of competition to inject more market forces in the health care area. Here we are thinking of competition between competing health care plans. We will want to look at some of these ideas. Certainly the regulatory systems that we have in place now under health planning are not models of success for dealing with the problems of increased costs. Much of the health care cost is the result of the third party payer system, which tends to inflate the whole system itself.

Our subcommittee has another area of jurisdiction that I think ought to be of concern to you also. We are the Health and Environment Subcommittee. A good number of the items that we deal with are public health issues. The ways I think we have to approach cost containment are by, at some point, seeing if we can eliminate some of the cost of treatment of diseases by prevention. One of the major items before us next year will be the Clean Air Act which deals with the strategies the states will adopt to clean up the air in our polluted cities. I worry about the assault on the Clean Air Act because the Act is really a very delicate balance between very legitimate business issues and environmental issues. Pollution does poison us -- it has an adverse impact on public health. Among the legitimate needs which must be taken into consideration are the growth of our economy and the means to develop new energy resources. This is particularly true as we look to coal and other domestic resources for energy independence and not to oil importation to meet all our energy needs.

We will have bills next year before our subcommittee which deal with funds for the states for other public health programs. There will be a whole range of bills that must be authorized as these programs are continued. We have worked in a bipartisan way in the past and I expect we will in the future. Even with the change in the Administration and in the Senate, I think we are going to be looking to come together to deal with real needs.

One area I will be working on especially next year is a bill dealing with the program called the Medicaid Community Care Act. This will expand outpatient benefits for older Americans who remain outside nursing homes and hospitals. Many of our older people can live at home, can function in the community with supportive services, rather than be put into institutions. It seems to me a lack of humanity on our part to institutionalize people who can function at home. It also makes no sense fiscally. The cost of institutionalization is far greater. This bill would give incentives, in time, to change the direction of services needed for our older people.

As we look at all these items; as we approach the issues of competition in the health care area versus regulations in the health care area, or as we address specific changes in the reimbursement system, we need you to participate in that process for decision-making. We need your profession and your specialty to come forward and let us know how pathology is going to be affected by the changes we make.

I am again honored to be with you to encourage you to not just have this successful meeting here in San Francisco, but to have many more. I look forward to working with you and Mike Allen and his associates in Washington so that we may approach these problems together. I thank you for your extraordinary courtesy

Given the restraints of time and the hunger you may be experiencing, I will stop now, and I will be happy to take any questions.